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The Role of a Father in Access to Maternal and Child Health Services in Ethiopia: A Neglected Key to Survival

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Abstract

Children's survival and health critically depend on supportive adults, particularly their parents. Sub-Saharan Africa and Central and Southern Asia bear the highest burden of maternal, stillbirth, and neonatal deaths. Ethiopia ranks 5th globally among countries accounting for 60% of these deaths. The major underlying causes are harmful gender norms, biases and inequalities. This study identifies factors affecting male involvement in Maternal and Child Health (MCH) care in Ethiopia and proposes strategies to enhance father's contributions to maternal and child survival. Methodologically, an extensive literature review and critical analysis of existing studies, health policies, and reports related to MCH, and father's role was conducted. Despite Ethiopia's health system improvements that incorporate life-cycle services, significant inequalities persist by economic status, education, residence, and gender. Political commitment to reducing stillbirths remains insufficient. Key barriers to male involvement include health facility factors (inaccessibility, unwelcoming environments, disrespectful care), sociodemographic characteristics (age, education, occupation), low income, and deep-rooted cultural norms relegating MCH to women's domain. In conclusion, the crucial role of father's in MCH care is widely acknowledged yet underexplored in the policy. Ethiopian men's hesitancy to engage in MCH significantly impacts survival outcomes. Implementing policies promoting male involvement – such as father-friendly clinics, targeted education campaigns, and couple-based antenatal care – can strengthen health systems and improve family well-being.

Keywords: *Ethiopia, Father Involvement, Maternal and Child Health, Paternal Support, Survival.*

Introduction

Since the 1994 International Conference on Population and Development (ICPD), male involvement in Maternal and Child Health (MCH) care has gained global recognition [1, 2]. However, engagement remains low in most Low- and Middle-Income Countries (LMICs), including Ethiopia [3]. Global evidence consistently demonstrates that male involvement positively impacts family planning use, antenatal care (ANC) attendance, safe birth practices, postnatal care (PNC), and child health service utilization [4].

Mothers and children are universally recognized as highly vulnerable population groups, disproportionately suffering from adverse social and economic conditions [5]. Children's vulnerability stems from their dependence on caregivers, primarily their parents for survival and health, especially from birth to age five. Maternal vulnerability arises from the inherent risks of pregnancy and childbirth [5].

The World Health Organization (WHO)'s 2030 targets aim to reduce the Global Maternal Mortality Ratio (MMR) to <70/100,000 live births (SDG 3.1), reduce neonatal mortality to

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≤12/1,000 live births and under-5 mortality to ≤25/1,000 live births (SDG 3.2) and achieve ≤12 stillbirths/1,000 total births (ENAP Goal 2), [6]. Sub-Saharan Africa (SSA) and Central/Southern Asia bear the highest burden of maternal deaths, stillbirths, and neonatal deaths. Ethiopia ranks 5th among the top 10 countries accounting for 60% of these global deaths [7], (Table 1).

Table 1. Countries with the Largest Numbers of Maternal Deaths, Stillbirths, and Neonatal Deaths in 2020

Country	Total Deaths (thousands)	Share of Total Deaths	Share of Live Births	Maternal Deaths (thousands)	Stillbirths (thousands)	Neonatal Deaths (thousands)
India	788	17%	17%	24	297	468
Nigeria	540	12%	6%	82	181	277
Pakistan	474	10%	5%	10	207	257
DRC	241	5%	3%	22	113	106
Ethiopia	196	4%	3%	10	83	104
Bangladesh	121	3%	2%	4	66	51
China	108	2%	9%	3	63	42
Indonesia	103	2%	3%	8	42	53
Afghanistan	95	2%	1%	9	38	49
Tanzania	94	2%	2%	5	43	46

Source: UN World Population Prospects 2022, UN MMEIG 2023, UNIGME 2023

Harmful gender norms, biases, and inequalities are major underlying causes of maternal mortality and impact newborn survival [7]. While Ethiopia has made significant strides in reducing under-5 mortality (from 123/1,000 in 2005 to 59/1,000 in 2019) and infant mortality (from 77/1,000 to 47/1,000), maternal (401/100,000 in 2017) and neonatal mortality (33/1,000 in 2019) remain high [8, 9] (Figure 1).

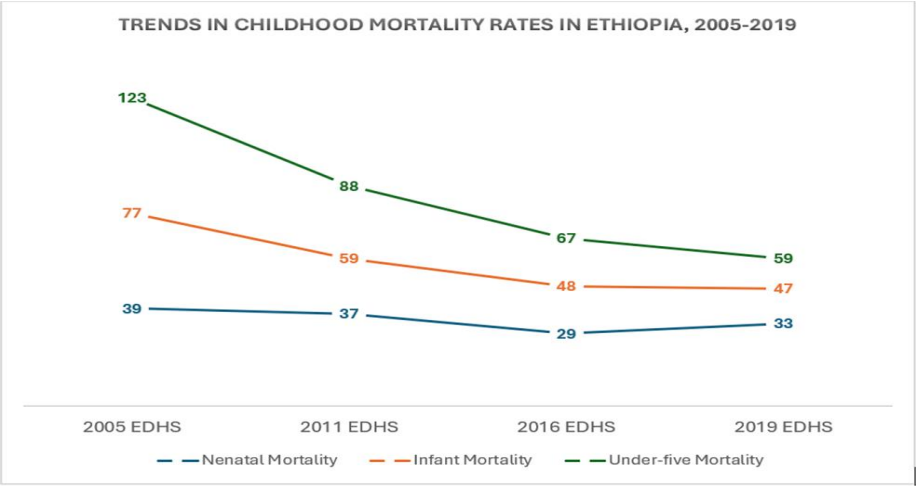

Figure 1. Trends in Childhood Mortality Rates, 2005 – 2019

(Source: Ethiopian Health Sector Transformation Plan II (HSTP II): 2020/21 – 2024/25)

Persistent challenges include sociocultural beliefs, facility-related issues (poor satisfaction, disrespectful care, accessibility, stockouts), and low community health knowledge [8].

Significant disparities exist between urban and rural areas in MCH service uptake and male involvement, with urban areas showing better outcomes [10].

Paternal support demonstrably enhances MCH outcomes. Father involvement leads to the following benefits:

1. **Improved Maternal Health:** Reduced stress/anxiety/depression, increased ANC and PNC attendance, and shared responsibilities.
2. **Improved Child Health & Development:** Higher rates of immunization, growth monitoring, and timely treatment; better nutrition and food security.

This study aims to identify the key factors affecting male involvement in MCH services in Ethiopia and to propose strategies to enhance their contribution to maternal and child survival.

Policy Support

Global policy tracking reveals gaps. While 83% of reporting countries have national targets for reducing Maternal Mortality Ratio (MMR) and Neonatal Mortality Rate (NMR), commitment to reducing stillbirths is insufficient—only 31% have targets, and 34% of those are off-track for 2030 goals [7].

Financing is often misaligned: only 61% of countries have costed Maternal and Newborn Health (MNH) plans, 49% track MNH allocations, and few have specific budget lines for Emergency Obstetric Care (EmOC), (28%) or Small and Sick Newborn Care (SSNC), (22%). Only 12% report fully financed MNH plans [7].

Globally, the Reproductive, Maternal, Newborn, and Child Health (RMNCH) sub-index improved by 12% between 2000-2019, yet significant gaps persist, especially regarding Sexual and Reproductive Health and Rights (SRHR) for marginalized groups and in crises [11, 12].

Ethiopia's Health Sector Transformation Plans (HSTP) prioritized MCH, aligning with global initiatives like the Millennium Development Goals (MDGs). Newborn health gained prominence post-2010. Strong alignment among development partners under a single national framework (e.g., regular joint assessments) has been a feature [13]. The Reproductive, Maternal, Neonatal, Child, Adolescent and Youth Health plus Nutrition (RMNCAYH+N) strategy integrates services across the life cycle [8]. The foundational Health Extension Program (HEP), launched in 2003, expanded preventive MCH services [14].

Despite progress, significant inequalities persist in economics, education, residence, and gender. The 2019 Ethiopia Mini DHS (EMDHS) shows improvements (e.g., ANC1: 28% in 2005 to 74% in 2019), but critical gaps remain: only 43% had 4+ ANC visits, 20% started ANC early, 50% facility deliveries, 10.6% received adequate iron, 14% delivered in functional Emergency Obstetric and Newborn Care (EmONC) facilities, and low PNC (34% in 2019). Caesarean section rates were very low (4%) with huge regional disparities [9]. Neonatal disorders remain the leading cause of under-5 deaths (40.7%), with malnutrition contributing to nearly half of these deaths. The proportion of neonatal deaths rose from 43% (1990) to 55% (2019) of under-5 deaths [9]. Key challenges include uneven resource distribution, suboptimal quality of care, low care-seeking behaviour, low Kangaroo Mother Care (KMC) coverage, and commodity shortages [8].

Factors Influencing Male Involvement in MCH Care

Sociodemographic Characteristics

1. **Age & Marital Status:** Older age of the spouse and cohabitation are associated with higher male involvement [15].
2. **Education:** Higher education levels significantly increase male involvement. Men with ≥8 grade of education were twice as likely to be involved compared to those with no formal or less education [16].
3. **Occupation:** Demanding or unpredictable jobs (e.g., taxi drivers, motorbike taxi riders) reduce the likelihood of

accompanying spouses to health facilities [16].

Health Service Factors

1. **Geographical Accessibility:** Long distances to health facilities deter men, compounded by fears of roadside delivery and shame associated with it [17].
2. **Provider Attitudes & Behaviour:** Disrespectful, harsh, or critical treatment of both women and accompanying men, negative gender-based staff assumptions and attitudes toward men by healthcare workers (HCWs) are major deterrents that discourage future participation [16-18]. Additionally, HCWs lack awareness of and understanding of fathers' needs, contributing to poor communication and treatment of fathers in relation to MCH affairs [18].
3. **Clinic Environment & Space:** MCH clinics often lack space for men, mainly focusing on a mother-oriented environment of services, which creates an unwelcoming atmosphere for men. Men are frequently excluded from delivery rooms and immediate postpartum spaces, limiting their role in the provision of support despite showing interest [16, 18-20].
4. **Policy and Practice Guidelines:** Absence of specific policies, guidelines, and practical frameworks on father involvement in MCH programmes, as well as the presence of unfavourable workplace policies, become obstacles to father involvement in family health programs [18].

Income and Economic Factors

1. **Enabling Factor:** Higher and stable income correlates strongly with greater involvement in ANC, decision-making, and supporting maternal health behaviours [21-23]. Financial security reduces stress and increases time and flexibility for involvement [24].
2. **Barrier:** Poverty, lack of transport, and inflexible jobs hinder participation, especially in rural areas [15]. Even within "free" services, unexpected costs for supplies cause embarrassment and deterrence [17, 25]. Financial stress can reduce emotional and physical availability.

Cultural and Normative Factors

1. **Gender Role Division:** Deeply ingrained patriarchal norms designate MCH, particularly childbirth, as exclusively "women's affairs." Men's involvement is often seen as transgressing traditional roles, risking loss of respect and cause community stigma [17, 26-28].
2. **Provider Role:** Men are culturally defined as decision-makers and financial providers, not direct caregivers within the MCH sphere [19].
3. **Harmful Beliefs:** Beliefs associating male presence at delivery with infidelity, prolonged labour, or bewitchment, which discourage involvement [26, 27].
4. **Traditional Practices & Fatalism:** Preference for Traditional Birth Attendants (TBAs) and beliefs that childbirth is a natural process governed by divine will and power, reduces perceived need for facility-based care and male escort [17, 29].

Strategies for Future Improvement

Addressing low male knowledge and involvement requires multi-faceted interventions:

1. **Community-Level Interventions:** Design culturally sensitive programs (considering traditional roles, religion, work schedules, and education) to reorient men about their crucial role in Reproductive, Maternal, and Child Health (RMCH) and challenge patriarchal beliefs [3].

2. **Targeted Male Engagement:** Implement male-specific strategies: tailored health messages, dedicated education sessions, and identifying male-friendly venues (e.g., workplaces, community centers), [18, 20].
3. **Health System Adaptations:**
   - Create welcoming environments (father-friendly clinics with dedicated spaces), [18].
   - Train providers on respectful engagement of men and couples.
   - Promote couple-based ANC and PNC.
   - Implement flexible clinic hours.
4. **Socioecological Approach:** Utilize a framework addressing barriers at multiple levels (Figure 2):
   - Individual: Education, empowerment.
   - Relationship: Couple communication, shared decision-making.
   - Community: Challenging harmful gender norms through community dialogue, engaging leaders.
   - Societal/Structural: Supportive policies, media campaigns promoting positive fatherhood, addressing economic barriers [18, 30].

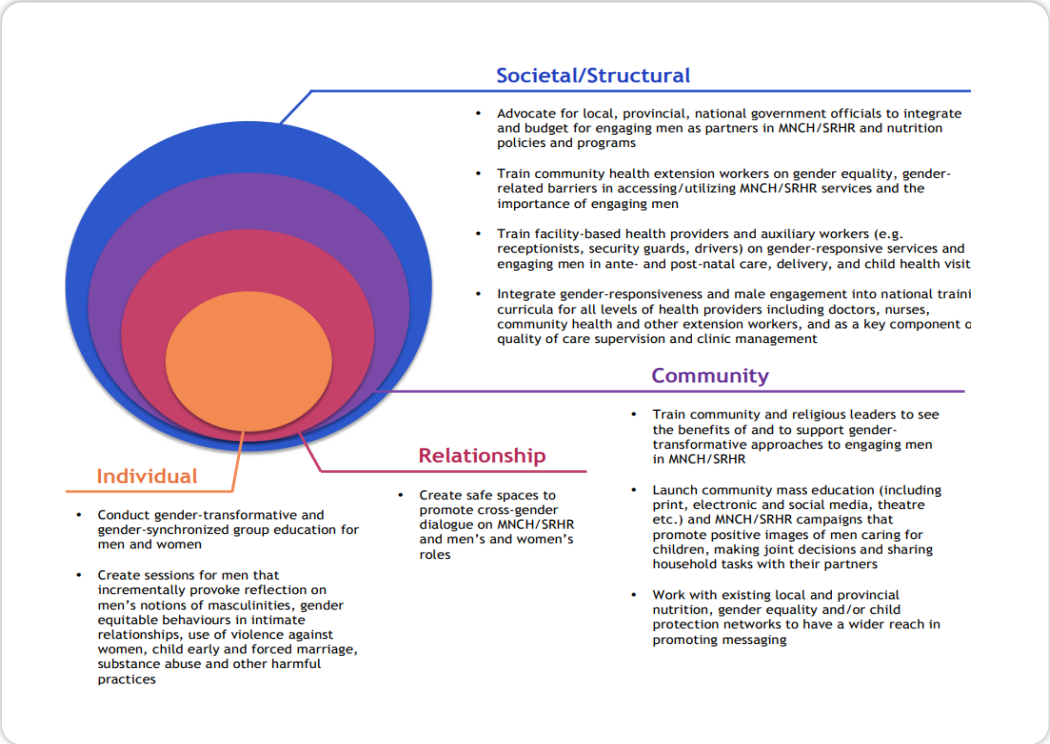

Figure 2. Strategies for Male Involvement in MCH Care

(Adopted from Doyle & Kato-Wallace, 2013)

(Visual depiction of concentric circles: Individual, Relationship, Community, Societal/Structural levels with corresponding intervention strategies listed at each level).

Discussion

This review underscores a critical role of fathers in MCH. While globally acknowledged, it remains a significantly underutilized mean of support within the Ethiopian health system [3, 4]. The findings align with broader literature from LMICs, confirming that male involvement is not a peripheral concern but a central determinant of MCH outcomes [4, 15]. The persistence of high maternal and neonatal mortality in Ethiopia, despite systemic improvements, highlights a crucial

implementation gap where engaging men could yield substantial survival dividends [8, 9].

The analysis reveals a complex barrier ecosystem. At the structural level, the absence of explicit policy directives and budgetary lines for male engagement programs signals a lack of institutional prioritization [7, 18]. This trickles down to health facilities, manifesting as physical and attitudinal environments that are exclusionary to men, such as unwelcoming clinic spaces and disrespectful treatment from healthcare workers [16-18]. Concurrently, deep-seated patriarchal norms at the community level enforce a rigid gender-based division of labour, casting MCH as a female domain and stigmatizing male participation [17, 26, 27]. These structural and normative barriers are compounded by individual-level factors like low education and economic constraints, which limit men's capacity and flexibility to engage [15, 16, 24].

However, the identified strategies point towards a viable pathway. The proposed multi-level socioecological approach is critical [18, 30]. Isolated interventions, such as training health workers without addressing community norms, or creating father-friendly spaces without flexible clinic hours for working men, are likely to fail [18, 20]. Success requires synergistic action. The health policy must mandate and fund male-inclusive MCH programming [7, 18]. Health systems must operationalize this through infrastructure, training, and couple-friendly service models [18, 20]. Communities must be engaged through trusted leaders and tailored communication to reframe fatherhood and masculine roles [3, 26, 30]. This integrated effort can transform father involvement from a neglected key into a powerful engine for achieving Ethiopia's MCH and Sustainable Development Goals (SDGs) [6, 8].

Conclusion

The vital role of fathers in MCH care, while acknowledged, remains critically underexplored and underutilized in Ethiopian health policy and practice. Paternal involvement is not merely beneficial but essential for improving maternal health outcomes, enhancing child survival and development, and strengthening family well-being. Ethiopian men's current low participation stems from a complex interplay of factors: entrenched patriarchal norms defining MCH as women's domain, health system barriers (inaccessibility, unwelcoming environments, disrespectful care), socioeconomic constraints (poverty, time limitations due to income generation), and varying levels of education and awareness.

Overcoming these barriers requires deliberate and sustained action. Policies and programs must actively promote male involvement through concrete measures: establishing father-friendly health facilities, implementing widespread education campaigns targeting men and communities to shift gender norms, promoting couple-based ANC and PNC models, and integrating strategies to address economic and logistical barriers. Successfully implementing these interventions holds immense potential to significantly reduce Ethiopia's high burden of maternal, neonatal, and child mortality, moving the country closer to achieving its national health goals and global SDG targets. Engaging fathers is not just an add-on; it is a neglected key to unlocking better survival and health for Ethiopia's mothers and children.

Ethical Approval and Concern to Participate

It is not applicable for this study.

Data Availability

Not applicable. This study is a literature review and does not involve original data.

Author Contributions

- **David Dak:** Conceptualization, Methodology, Writing – Original Draft, Writing – Review & Editing.

- **Dagnechew Degefu:** Writing – Original Draft, Investigation, Formal analysis.
- **Surender Reddy Pulluri:** Supervision, Validation, Writing – Review & Editing.

All authors reviewed and approved the final manuscript.

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Competing Interests

The author(s)declared no competing interests.

Disclaimer

The author(s)declared that no generative artificial intelligence (AI) technologies (e.g., ChatGPT, Copilot, Scite) were used in the preparation of this research paper.

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